2024 Employee Benefit Guide
(Non-Union Employees)
Plan Year: Jan 1-Dec 31, 2024

CLARKSON
CONSTRUCTION COMPANY

Medical - Dental - Vision - Life & AD&D – Voluntary Life – Disability – Health Savings Account – Employee Assistance Program – Retirement – Additional Benefits

Welcome!

Welcome to Clarkson! We're glad you're a part of the team and proud to provide you with this benefit program. We recognize the importance of delivering a comprehensive benefit program that meets the needs of you and your dependents and provides financial protection for employees in case of illness, injury, death or disability.

This guide outlines the resources available to help you evaluate your benefits options, understand the enrollment process, and make the best decisions for yourself, your family, and your lifestyle.

We want all employees to take advantage of the benefits offered to them, so please don't hesitate to ask questions or request more information. We're happy to help. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the Summary Plan Descriptions and official plan documents. If any discrepancy exists between this Guide and the official documents, the official documents will prevail.

G.G. Clarkson
c. 1880

Benefit Guide Contents

Important Contact Information

FOR QUESTIONS ABOUT	CARRIER CONTACT	GROUP #	PHONE #	WEBSITE
Medical Insurance	BCBS of Kansas City	43684000	816-395-3558 888-989-8842	MyBlueKC.com
Pharmacy Coverage	BCBS of Kansas City	43684000	800-228-1436	MyBlueKC.com
Telemedicine / Virtual Care	BCBS of Kansas City	43684000	Available through MyBlueKC App	
Health Savings Account	UMB Bank	UMB0003-00820064	866-520-4472	HSA.umb.com
Dental Insurance	Principal	1103065	800-247-4695	Principal.com
Vision Insurance	Carrier: Principal Network: VSP	1103065	800-247-4695 800-877-7195	Principal.com VSP.com
Life, AD&D, and Disability Insurance	Principal	1103065	800-245-1522	N/A
Employee Assistance Program (EAP)	New Directions	Company Code: Clarkson	800-624-5544	EAP.ndbh.com
Retirement 401(k)	Ascensus	252639	888-652-8087	Ascensus.com

If you have questions, concerns, or need support, please don't hesitate to reach out to Tara McKinney, Clarkson Vice President of Human Resources, at:

(816) 483-8800 office
(913) 433-3199 cell
tmckinney@clarksonconstruction.com

Call, text or email anytime.

Eligibility and Enrollment

Eligibility and Enrollment

All non-union employees who average 30 or more hours per week are eligible for the benefits described in this guide. Unless otherwise noted, you become eligible for the benefits described in this guide effective on your first day of employment. New hires make benefit elections during the onboarding process, or shortly after hire. For all other employees, the annual open enrollment period is during the month of November. All benefit elections will be made in your UKG portal.

Eligible Dependents

Your dependents are eligible for some of these benefits as well, where indicated. "Dependent" means:

- your legally recognized spouse
- Your dependent child under age 26. Dependent children can include your natural born child, step-child, legally adopted child, or child placed for adoption.

There may be other circumstances in which an individual would be considered a dependent. More information about this can be obtained from Human Resources. Coverage for eligible dependents begins on the same day your coverage is effective.

Making Changes to Your Benefit Elections

The benefits you elect at your time of hire (or open enrollment for existing employees) will be effective until the end of the current plan year. Once you have made your elections, you will not be able to make changes until the next open enrollment period, unless you experience a qualifying event status change. Qualifying events include, but may not be limited to:

- Changes in your legal marital status including marriage, death of your spouse, divorce, legal separation or annulment.
- Birth or adoption of a child.
- Your dependent satisfying or no longer satisfying the eligibility requirements due to age, or other circumstances.
- Loss of other coverage due to termination of employment, reduction in hours, exhaustion of COBRA or state continuation, or death.
- Becoming Medicare eligible.

You must notify Human Resources within 30 days from the date of any qualifying event status change in order to change your benefit elections!

Medical Benefits

Medical coverage provides you with benefits that help keep you healthy and provides important financial protection if a medical need or condition occurs. Clarkson has partnered with Blue Cross Blue Shield of Kansas City (BCBSKC) for the care you need at a reasonable cost to help protect you against the catastrophic costs of major illness or injury.

You have three medical plans to choose from. In every option, it's in your best interest to use in-network providers who have pre-negotiated service fees and to compare healthcare prices prior to receiving services. A complete listing of hospitals and physicians is available on MyBlueKC.com.

OPTION 1: Spira Care Exclusive Provider Organization (EPO)

Developed by Blue Cross and Blue Shield of Kansas City and the first of its kind in the KC metro, Spira Care combines integrated primary care and coverage in one place. Members enjoy low premiums, relative to other plan options, and there are no costs for any services received at any of the nine KC Metro Spira Care Centers. (Members will incur a copay charge for any generic prescriptions received at a Spira Care facility)

Spira Care members have two options for receiving care; visiting a Spira Care Center for primary care needs or seeing a provider in their plan's network. **Non-emergency services received out-of-network are not covered.** In addition to the SpiraCare Guides, who help coordinate care across all providers, members have access to primary care physicians, nurse practitioners, behavioral health consultants, health coaches, labs and more. Members enrolling in SpiraCare must live within the 12-county service area which includes the following counties:

- Kansas Counties: Johnson and Wyandotte
- Missouri Counties: Caldwell, Cass, Clay, Clinton, DeKalb, Jackson, Johnson, Lafayette, Platte and Ray

Spira Care EPO Plan

Spira Care (No Cost)	+	BlueSelect Plus EPO	+	BlueCard National Network
• $ No cost for any services at a Spira Care Center		• $ Member pays until out-of-pocket is met		• $ Member pays until out-of-pocket is met
• $ Member pays for prescriptions at regular cost-sharing level		• Local access to 3,600 Physicians & Specialists, 10 Hospitals		• Access to the BlueCard network providing in-network national and international medical care outside Blue KC's 32-county service area
• Integrated primary care		• Must receive care from in-network providers except for emergency services		• Non-emergency services received out-of-network will not be covered
• Access to Spira Care Centers, Care Teams and Care Guides		• Non-emergency services received out-of-network will not be covered		
• Must schedule appointment for all care needs including sick care				

OPTION 2:
Qualified High Deductible Health Plan (QHDHP) & Health Savings Account (HSA)

QHDHPs are PPO's that can be combined with a tax-favored Health Savings Account (HSA). QHDHPs offer you the freedom to receive care from any provider, in or out of your network. This means you can see any doctor or specialist, or use any hospital, though you will be charged significantly more out-of-network. HSA plans do not require you to choose a primary care physician and do not require referrals.

There are several advantages to an HSA. Your contributions, interest earned, and withdrawals to pay for qualified health care expenses are never taxed. Unused funds are always yours, regardless of your employment status. At age 65, you may use HSA funds for **any** purpose without penalty, (if not used for health care expenses, taxes still apply) and may use funds to pay Medicare premiums (part A, B and D only). With the exception of preventive care, which is covered at 100%, you are responsible for 100% of the cost of your healthcare, including prescription costs, until you meet your deductible.

In order to participate in an HSA, you:

- Must be enrolled in a QHDHP
- Cannot be covered as a dependent on someone else's tax return
- Cannot be covered by another non-QHDHP plan, including Medicare, Medicaid, or Tricare
- Cannot be covered by a regular FSA or eligible for a spouse FSA plan

For a full list of HSA eligible expenses, visit **irs.gov**.
Examples of common HSA eligible expenses are:

- Medically necessary expenses that are not covered by your health plan, including deductibles and coinsurance
- Dental, vision and hearing care services
- Prescription drugs and over-the-counter (OTC) medications prescribed by a healthcare provider
- Certain medical equipment, treatments, and therapies

For calendar year 2024, HSA holders can choose to save up to $4,150 for an individual or $8,300 for a family (HSA holders 55 and older may save an additional $1,000). Married couples with HSA-eligible family coverage will share one family HSA contribution limit of $8,300 in 2024. If both spouses have eligible self-only coverage, each spouse may contribute up to $4,150 in separate accounts. If both spouses with family coverage are age 55 or older, they must have two HSA accounts in separate names if they each want to contribute an additional $1,000 catch-up contribution. If only one spouse is 55 or older but the younger spouse contributes the full family contribution limit to the HSA in his or her name, the older spouse must open a separate account to make the additional $1,000 catch-up contribution.

Account holders who exceed the contribution limit are subject to an annual 6 percent excise penalty tax on the excess amount unless it is withdrawn from the HSA before the tax deadline for that year. These are IRS limits and include any Clarkson contribution, if applicable. When possible, use your HSA debit card to pay for expenses. Make sure to keep records of your receipts in the event you are audited by the IRS.

For the 2024 plan year, and to assist HSA participants with possible out-of-pocket expenses, Clarkson will make weekly contributions to HSA participants who also make weekly contributions to their own HSA account. Clarkson's weekly contribution will be $10/weekly pay period for employees with no dependents on the plan ($520 annual equivalent), and $20/weekly pay period for employees with dependents on the plan ($1040 annual equivalent).

Your UMB HSA debit card helps simplify payments for health care services and makes tracking easy.

OPTION 3: Preferred Provider Organization (PPO)

A PPO offers you the freedom to receive care from any provider, in or out of your network. This means you can see any doctor or specialist, or use any hospital, though you will be charged significantly more out of network. In addition, PPO plans do not require you to choose a primary care physician and do not require referrals.

With more flexibility than the Spira Care option, and a lower deductible than the HSA option, this plan option has the highest premiums and annual out-of-pocket maximum for employees.

Medical Plan Comparison

Plan Provision	Spira Care EPO		$3,200 Deductible HSA		$1,000 Traditional PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
***Deductible** Individual/Family	$3,500 / $7,000	Not Covered	$3,200 / $6,400		$1,000 / $3,000	
Coinsurance	0%	Not Covered	0%	20%	20%	50%
***Maximum Out of Pocket** Individual/Family (Includes all Copays, Deductible & Coinsurance)	$3,500 / $7,000	Not Covered	$3,200 / $6,400	$6,400 / $12,800	$4,000 / $8,000	$8,000 / $16,000
Preventive Care	No Cost	Not Covered	No Cost	Deductible + 20%	No Cost	Deductible + 50%
Office Visit: Primary or Specialist	Spira Care: **No Cost** Other: Deductible	Not Covered	Deductible	Deductible + 20%	$30 Copay	Deductible + 50%
Urgent Care	Deductible	Not Covered	Deductible	Deductible + 20%	$30 Copay	Deductible + 50%
Blue KC Virtual Care	No Cost	Not Covered	No Cost	Not Covered	No Cost	Not Covered
Hospital: Inpatient or Outpatient	Deductible	Not Covered	Deductible	Deductible + 20%	Deductible + 20%	Deductible + 50%
Emergency Room	Deductible	Not Covered	Deductible		$100 Copay + Deductible + 20%	
Retail Prescription Tiers 1 / 2 / 3 / 4	$15 / $50 / Deductible	Not Covered	Deductible	Deductible + 50%	$15 / $70 / $110 / $200	Copay + 50%
Mail Order Prescription Tier 1 / 2 / 3	$15 / $125 / Deductible	Not Covered	Deductible	Deductible + 50%	$37.50 / $175 / $275	Copay + 50%

*Using In-Network providers and facilities saves you significant out-of-pocket expenses. Finding in-network providers and facilities is fast and simple. See the contacts page of this Guide for carrier contacts.

Getting Care When you Need It

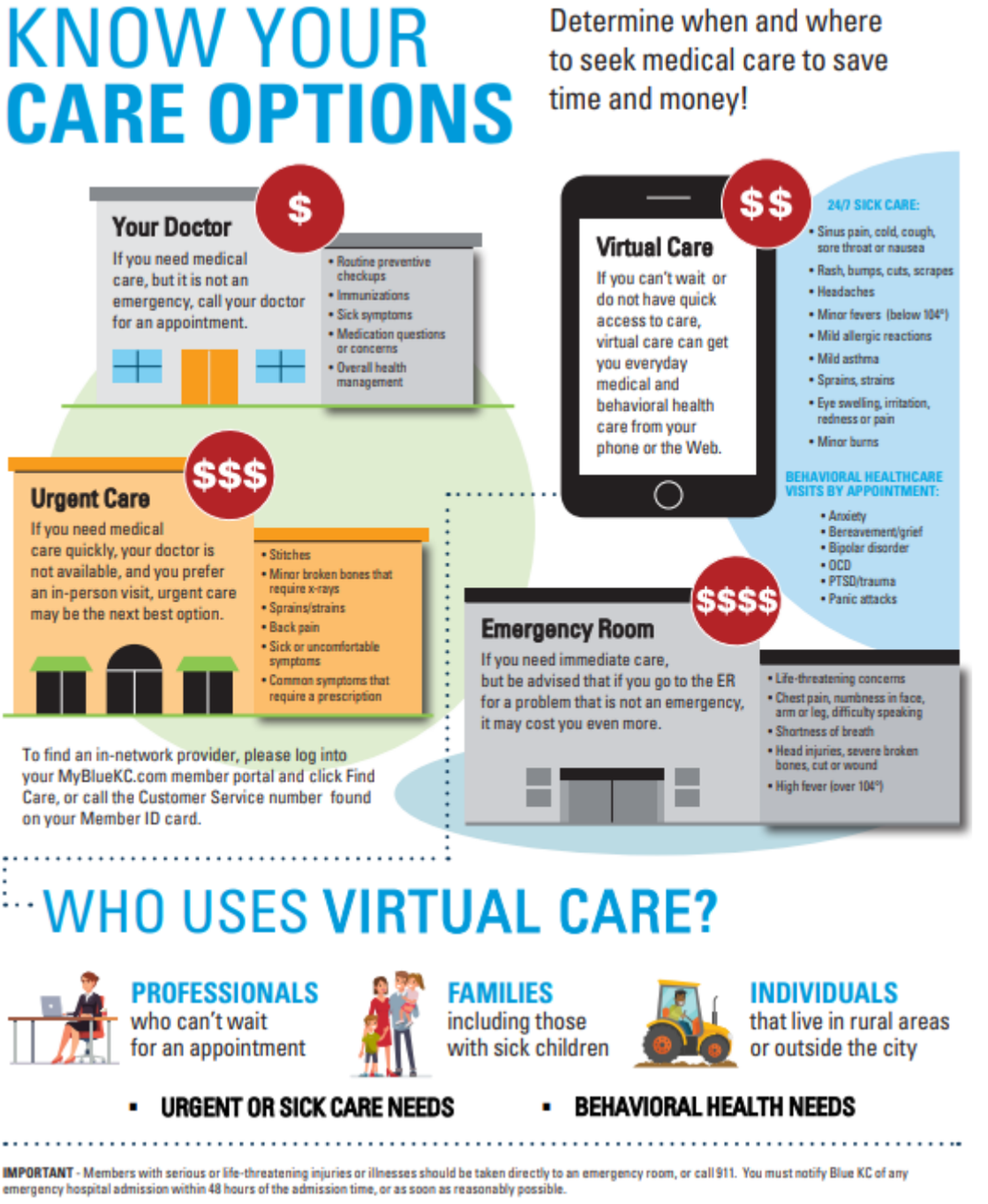
With many options to get care quickly, it can be confusing knowing where to go and how much you might have to pay. To find a doctor or hospital, estimate your medical costs using the cost estimator tool, and learn ways to save, visit MyBlueKC.com, select **FIND CARE**, then select **FIND A DOCTOR OR HOSPITAL**.

In addition to the options below, Spira Care members have the Spira Care Clinic option for no-cost care, but no coverage for out-of-network, non-emergency services.

More than **80% of all visits to the emergency room** could have been managed in less time and at a lower cost to you by your primary care doctor, an urgent care center, a telehealth provider, or walk-in clinic.

For common concerns, you can **refer to this chart** to determine which type of facility will provide the best care at the lowest cost to you.

Search for hospitals, pharmacies, walk-in clinics and urgent care centers at **mybluekc.com**. You may also contact Blue KC customer Service by calling the phone number printed on your Member ID Card.



Dental Insurance

Regular visits to your dentist can protect more than your smile, they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease. Clarkson has partnered with Principal to offer you the two dental plan options shown below. To find an in-network dentist, visit principal.com/dentist.

Base Plan	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 / covered person $150 / family	
Annual Plan Maximum	$1,000 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than $500.	
Buy-Up Plan	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$50 / covered person $150 / family	
Annual Plan Maximum	$1,500 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Orthodontic Services	50% up to a $1,500 Lifetime Maximum per eligible dependent	50% up to a $1,500 Lifetime Maximum per eligible dependent
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than $750.	

*Out-of-network claims are processed using prevailing fees at the 90th percentile. Member may be billed for amount above allowed fee.

Vision Insurance

Comprehensive eye exams not only correct vision but can also detect many critical diseases and health conditions, like diabetes, cancer, cataracts, glaucoma, macular degeneration, and more. We have partnered with Principal to offer this voluntary vision plan. Voluntary benefits are those where there is no employer contribution to the plan.

As with all our insurance plans, using in-network providers will offer you the highest coverage and keep your out-of-pocket costs as low as possible. To find an in-network provider, visit principal.com and click on Locate a Provider.

Benefit	In-Network	Out-of-Network Allowance
Eye Exam		
Copay	$10 Copay	N/A
Frequency	Every 12 Months	Every 12 Months
Allowance	100%	Up to $45
Prescription Glasses		
Copay	$25 Copay	N/A
Frequency	Every 12 Months	Every 12 Months
Single Allowance	100%	Up to $30
Bifocal Allowance	100%	Up to $50
Trifocal Allowance	100%	Up to $65
Lenticular	100%	Up to $100
Frames		
Frequency	Every 12 Months	Every 12 Months
Allowance	$130 + 20% off remaining amount	Up to $70
Contact Lenses		
Lens Fitting Copay	Up to $60 Copay	N/A
Elective	$130 Allowance	Up to $105
Medically Necessary	Covered in Full after $25 Copay	Up to $210

Laser Vision Correction

Discounts and services available in tandem with the Principal vision benefits include Laser vision correction. Employees, their spouses and dependent children save $800 with featured providers Lasic***Plus***, TLC Laser Eye Centers, or The LASIK Vision Institute or receive 15% off standard pricing or 5% off promotional pricing on LASIK through the National Lasik Network's administered by LCA Vision.

Principal.com gives you quick access to your vision benefits information. Member account information is shared by all covered family dependents.

Easily locate providers, view your benefits and eligibility, download forms, and more.

Register online to get started!

Basic Life and AD&D

If you have loved ones who depend on your income, Basic Life and Accidental Death and Dismemberment (AD&D) insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses. Clarkson provides these benefits, at no cost to you, through Principal.

Basic life insurance pays your beneficiary a lump sum if you die, with a benefit of one time (1x) your annual salary, rounded to the next highest $1,000 and subject to a maximum of $200,000. The amount of coverage will be reduced by 35% of the original amount at age 65, and by 50% at age 70. AD&D provides another layer of benefit to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The amount is equal to your basic life benefit.

Voluntary and Dependent Life and AD&D

Voluntary life and AD&D is additional coverage you can purchase on top of the employer-paid benefit outlined above. Employees can purchase insurance to cover themselves, their spouse and/or children. Employee voluntary life is required to purchase spouse or dependent child coverage.

Spouse rates are based on the spouse's age. Child(ren) rates do not change, regardless of the number of children covered. The amount of coverage will be reduced by 35% of the original amount at age 70, and by 45% when you reach age 75.

If you request more than the guaranteed issue life insurance amount, or if you request to increase your coverage or add coverage outside of your initial offering, you will be required to complete a health history questionnaire for approval by the provider.

Voluntary Life Coverage Level Options	
Employee Voluntary Life / AD&D	$10,000 increments up to $500,000 Guaranteed Issue is $100,000 (under age 70)
Spouse Voluntary Life / AD&D	$5,000 increments up to $150,000 Guaranteed Issue is $30,000 (under age 70)
Child(ren) Voluntary Life / AD&D	$2,000, $4,000, or $10,000 $100 under six months of age Birth to six months max benefit $1,000

Monthly Rates for Voluntary Life / AD&D By Age Band										
Adult Age Bands	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Adult Rate (per $1,000)	$0.131	$0.140	$0.184	$0.266	$0.383	$0.592	$0.900	$1.229	$2.226	$3.622
Dependent Child(ren)	$2,000 benefit $0.40/month - $4,000 benefit $0.80/month - $10,000 benefit $2.00/month									

_____ / $1,000 X _____ = Premium Per Month

Amount of coverage
(for employee, increments of $10,000 up to $500,000)

Age Rate
(ex: 36-year-old pays $0.184)

Short-Term Disability

If you are unable to work due to a qualified short-term disability, including maternity leave, Clarkson provides a short-term disability ("STD") plan through Principal. STD benefits help replace a portion of your income for up to 11 weeks if you unable to work due to non-work-related injury or illness. There is no cost to you for this coverage.

Employees with approved STD claims receive a benefit amount equal to 70% of their regular gross salary, excluding bonuses and commission, up to a maximum benefit of $2,500 per week. The elimination period (waiting period after the disability starts but before the benefit is paid) is 14 days. During the 14-day elimination period employees may use accumulated vacation or sick time to help cover lost earnings.

Work-related sickness, injury, or other disability are not covered under STD as they are covered under our worker's compensation insurance.

Long-Term Disability

A Long-Term Disability ("LTD") can be a devastating financial blow. In order to protect employees' financial needs during a LTD, Clarkson provides LTD coverage through Principal. This benefit is provided at no cost to employees. LTD coverage provides disabled employees with 66.67% of their regular gross salary, excluding bonuses and commissions, up to a maximum benefit of $7,500 per month. The elimination period (waiting period after the disability starts but before the benefit is paid) is 90 days.

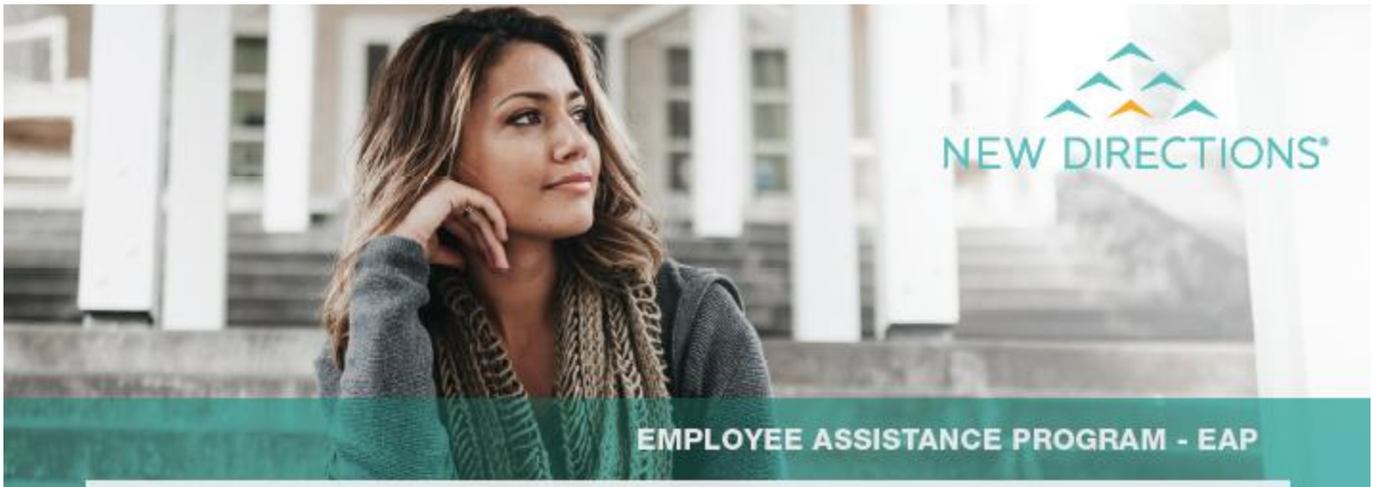
For the first two years of your disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education. The benefit duration for LTD is until Social Security Normal Retirement Age for individuals under age 65. Individuals age 65 or over have a limited benefit duration as follows:

- Age 65-67 – 24 months
- Age 68-69 – 18 months
- Age 70-71 – 15 months
- Age 72 and over – 12 months

HOW TO FILE A SHORT-TERM OR LONG-TERM DISABILITY CLAIM:

Disability claims must be completed online or on paper. If you need assistance filing a disability claim, please see Human Resources or call the Principal Claims Hotline at (800) 245-1522, weekdays, 7:00am to 5:00pm, CST for assistance. Refer to your member ID (social security number) and your plan number: 1103065

Employee Assistance Program (EAP)



NEW DIRECTIONS®

EMPLOYEE ASSISTANCE PROGRAM - EAP

When life's a little much, reach out and get in touch.

Let's be real: life can be tough. When your responsibilities start to feel overwhelming and showing up each day with a smile on your face seems difficult, it's important to reach out for help. You can lean on your free and confidential Employee Assistance Program (EAP) for support.

We've got your back.

A free benefit from your workplace, the EAP can help you or anyone in your household:

- Be more present and productive at work
- Receive support when you don't feel like yourself
- Get help with responsibilities that are distracting or stressful
- Grow personal and career skills
- Be a caring, loving friend or family member
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life

We're here for you, always.

Life happens, regardless of the day or time. That's why we make ourselves available 24/7, even on holidays. So whenever you need to reach out, we're here for you.

Support Line
Call anytime
800-624-5544

Mobile app
Search for New Directions EAP

Web
Visit eap.ndbh.com for resources

SERVICES

- ☑ Counseling
  - In-person
  - Telephone
  - In-the-moment
  - Online messaging
- ☑ Consultation on
  - Finances
  - Legal needs
  - Managing employees
  - Life
- ☑ Crisis support
- ☑ Coaching
- ☑ Adult and child care resources
- ☑ Personal and professional training
- ☑ Digital behavioral health tools

eap.ndbh.com
Code: Clarkson
800-624-5544

Services are free and your employer will not know you reached out.
Flip this sheet over to see some common reasons people use EAP.

EAP (Continued)

Whatever life throws your way, we're here to help.

Stress, relationships, work and money. These are the most common reasons people reach out to the EAP every year. But no matter what issues you're facing, the EAP is the perfect first step for you or your family members to:

Reduce stress
Some stress can be a good thing, but too much can be debilitating and unhealthy. Counseling, assessments, coaching, apps, meditation practices, online tools and more can help you improve areas that need work.

Handle a life curve ball
Divorce, adoption, losing a loved one, career changes and moving can all interrupt one's daily life. Counseling, thousands of online tools, coaching and consultations can help you adjust.

Cope after crisis
Mentally processing and coping after a traumatic event generally takes time and expert care. Counseling, education sheets and communication can help when a crisis occurs.

Support and improve relationships
Raising kids, living with others or improving friendships can take guidance and investment. Counseling, videos, tip sheets and advice make this easier. Referrals to credible daycares, assisted living facilities, dog walkers, physicians, etc. can also help.

Focus at work
We all experience feeling a lack of productivity and engagement at work sometimes. Trainings, advice and custom behavioral strategies can help you become more focused.

Lead others
If you supervise people at work, it's likely you handle difficult things like performance issues, troubled employees, HR law and hard conversations. Dedicated consultants can provide guidance so you can do your job and have less stress.

Navigate the legal system
Handling a landlord, large purchase, estate or even an infraction can be easier with the help of a legal expert and thousands of online templates to put into action.

Reduce debt
Money worries can be minimized with custom action plans developed with a financial expert to save, reduce debt or afford a life desired.

Live a healthy life
Changing behaviors to quit smoking, lose weight, manage a disease or exercise more can be more manageable when broken into baby steps. Coaching, videos, counseling and digital tools can help you start living healthy.

"The EAP has been beneficial in so many ways I don't know how I would have gotten through without it."

Check out our app.

Search for **New Directions EAP** in your app store.

Available on Google Play

Available on the App Store

Take the first step and call today.

eap.ndbh.com
Code: Clarkson
800-624-5544

EAPM15-20200326

Retirement / 401(k)

Clarkson offers a 401(k) Plan to assist you in saving for retirement. You may choose from a pre-tax or after-tax Roth 401(k) option (or both) and may contribute as much as you wish, within the legal limits set by the IRS. Clarkson provides a matching contribution of 50% of the first 6% of pay you contribute, which is vested over a three-year period.

When Can I Start Saving?

You become eligible to participant in our plan on the first day of the month following 2 months of employment. You must be 21 years of age or older to participate.

Your Contributions

Participants may contribute to the plan on a pre-tax basis, which helps lower your taxable income. Your plan also offers a Roth feature, which allows you to contribute to your retirement account on an after-tax basis. Your contributions to a Roth 401(k) grow tax-free and are tax-free upon withdrawal (if certain conditions are satisfied).

You may select your contributions in whole percentages to be deducted from your gross pay. The maximum 401(k) contribution for 2024 is $23,000 (additional $7,500 catch-up contribution for employees age 50 or older). These maximums are set by the IRS.

Automatic Enrollment and Contribution Increases

Your plan makes it easier to save for your future by automatically enrolling you. Unless you elect otherwise, you will be automatically enrolled in the pre-tax 401(k) plan with a 6% contribution.

Annual automatic increases of 1% will occur every Jan 1, up to a maximum of 15%. This automatic increase applies to all participants; however, you can opt out each year.

You can change your contributions at any time on the Ascensus website, ascensus.com, or by calling 1-888-652-8087.

Paid Time Off (PTO)

Regular employees on active status accrue paid time off ("PTO") based upon their years of active service. Active service commences with an employee's first day of work and continues thereafter unless broken by a leave of absence, or termination of employment. Temporary and part-time employees, and employees on any leave of absence including but not limited to FMLA, Short-Term Disability or Long-Term Disability, do not accrue PTO.

Employees begin to accrue PTO upon date of hire and may use PTO for any reason, as work schedules permit and subject to supervisor/manager approval. For scheduling purposes, we ask that all PTO requests are submitted to supervisors/managers with as much notice as possible. For operational purposes, supervisors/managers reserve the right to decline a PTO request.

PTO rolls over from year to year and can accrue up to a maximum balance equivalent to the employee's total annual accrued hours + 40 hours. Once this maximum balance is reached, the employee will not accrue PTO until some PTO is used allowing for additional accrual up to the maximum.

Except where otherwise stated, employees are required to use available PTO before taking an unpaid leave or having unpaid absences of any kind including, but not limited to, FMLA, Short-Term Disability or Long-Term Disability. Employees may use up to one week (40 hours) of PTO that has not yet accrued. In other words, an employee's PTO balance can be negative by up to 40 hours.

For non-exempt, hourly paid employees, PTO hours do not count the same as regular worked hours (will not be included) for weekly overtime calculations. PTO accrues on the following basis:

Years of Active Service	PTO Hours Accrued / Pay Period	PTO Hours Accrued / Year	PTO Days Accrued / Year	PTO Hours Maximum Balance
Hire Date – Year 5	2.308	120	15	160
Beginning of 6th Year – Year 10	3.077	160	20	200
Beginning of 11th Year +	3.847	200	25	240

Employees who terminate employment for any reason will be paid for accrued, unused PTO.

Paid Holidays & Leaves

Paid Holidays

Clarkson provides one work-day / 8 hours of holiday paid for the following observed holidays:

- New Year's Day (January 1st)
- Memorial Day (Last Monday in May)
- Independence Day (July 4th)
- Labor Day (First Monday in September)
- Thanksgiving Day (4th Thursday in November)
- Day after Thanksgiving
- Christmas Eve (Dec. 24th)
- Christmas Day (Dec. 25th)
- New Year's Eve (Dec 31st)

Holidays that fall on a Saturday or Sunday are usually observed on the preceding Friday or the following Monday. However, Clarkson may grant another day off in lieu of closing. Holiday observance will be announced in advance.

Employees are eligible for holiday pay immediately upon hire. Hourly-paid employees who are required to work on a paid scheduled holiday will receive their regular pay in addition to holiday pay. Hours paid as holiday pay do not count the same as regular worked hours (will not be included) for weekly overtime calculations. Part-time employees working a minimum of 20 hours per week receive 4 hours of holiday pay per holiday.

Paid Jury Duty Leave

We encourage employees to serve on jury duty when called. Employees will receive full pay while serving up to 40 hours / 5 business days of jury duty. You should notify your supervisor or manager of the need for time off for jury duty as soon as a notice or summons from the court is received, as well as provide a copy of the court summons. You may be requested to provide written verification from the court clerk of performance of jury service. If work time remains after any day of jury selection or jury duty, you will be expected to return to work for the remainder of your work schedule.

Paid Parental Leave

Employees requiring parental leave for the birth or adoption of their own child will be paid 100% of normal hourly wage or salary up to 40 hours / 5 days. Pregnancy disability leave / maternity leave and related pay is covered under the provisions of the FMLA and Short-Term Disability policies. Parental leaves may run concurrently with FMLA, if applicable.

Paid Bereavement Leave

We understand that a death in your family is devasting. To give employees necessary paid time to attend to family matters, Clarkson grants paid bereavement leave to employees who experience a death in the family as follows:

- 80 hours / 10 work days for death of employee's spouse or children
- 40 hours / 5 work days for death of employee's mother, father, siblings
- 24 hours / 3 work days for employee's mother-in-law, father-in-law, siblings-in-law, grandparents, or grandchild.

Paid bereavement leave must be approved by the Company. Supervisors and managers may approve additional unpaid bereavement leave to allow an employee more time during their time of need.

Corporate Gym Membership

Regular exercise helps prevent excess weight gain, combats health conditions and diseases, improves mood, boosts energy, and promotes better sleep. Clarkson has partnered with the YMCA to offer employees and their families gym membership benefits at every YMCA location in the nation.

You and all your household members are eligible for this benefit. In addition to enjoying lower rates due to our corporate membership, Clarkson subsidizes the monthly cost. We can't make working out easy, but we have made it affordable!

Notary Services

Clarkson is fortunate to have several notary publics on staff who are more than happy to notarize your documents at no charge. If you have a need for notary services, please see Human Resources for more information.

Principal Hearing Aid Program

Protect your hearing health to improve your quality of life. You, your spouse, children, parents and grandparents can get exclusive discounts up to 48% off on hearing aids, including rechargeable and Bluetooth -options, with a 60-day trial to ensure your full satisfaction. You can also receive a free hearing consultation at any of their 3,000+ locations nationwide.

Visit principal.com/hearingbenefits/ahb or call 877-890-4694 to learn more!

Benefit Rates (Your Costs)

With the exception of voluntary life insurances and corporate gym membership, which are after-tax deductions, your contributions to your elected plans are deducted pre-tax each pay-check date.

Blue Cross Blue Shield of Kansas City Medical Insurance		
$3,500 Spira Care	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$21.97	$95.22
Employee + Spouse	$55.38	$239.96
Employee + Child(ren)	$42.41	$183.78
Family	$62.85	$272.33
$3,200 HSA Base Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$25.74	$111.55
Employee + Spouse	$64.86	$281.04
Employee + Child(ren)	$58.46	$253.34
Family	$99.64	$431.76
$1,000 PPO Buy-Up Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$54.93	$238.05
Employee + Spouse	$118.66	$514.20
Employee + Child(ren)	$106.06	$459.59
Family	$166.09	$719.74
Principal Dental Plans		
Base Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$1.18	$5.12
Employee + Spouse	$7.81	$33.84
Employee + Child(ren)	$14.93	$64.69
Family	$23.19	$100.50
Buy-Up Plan	**Your Cost Per Check**	**Your Cost Per Month**
Employee Only	$3.77	$16.32
Employee + Spouse	$12.28	$53.21
Employee + Child(ren)	$18.05	$78.22
Family	$28.27	$122.51
Principal Vision Plan		
Employee Only	$1.64	$7.09
Employee + Spouse	$3.27	$14.18
Employee + Child(ren)	$3.30	$14.32
Family	$5.21	$22.59
YMCA Corporate Gym Membership		
Employee Only	$6.69	$29.00
Employee + Dependent(s)	$13.38	$58.00
Principal Basic Life & AD&D		
Paid 100% by Clarkson Construction.		
Principal Short-Term and Long-Term Disability Insurance		
Paid 100% by Clarkson Construction.		
New Directions Employee Assistance Program (EAP)		
Paid 100% by Clarkson Construction.		
Principal Voluntary Life & AD&D Insurance		
Rates vary by age and amount you elect. Please see detail page.		

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued…

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in-network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right o be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code, and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives' conflict, the Plan document will control.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162 ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: http://dhs.iowa.gov/ime/members
Medicaid Pone: 1-800-338-8366
Hawki Webite: http://dhs.iowa.gov/Hawki
Hawki Phoe: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid Hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: http://www.coverva.org/en/famis-select
http://www.coverva.org/en/hipp
Medicaid and CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-126

If you live in one of the above states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your state for more information on eligibility. To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have credible health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government, or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying for low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, the PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the company, you will lose any employer contribution made for your health coverage and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **www.healthcare.gov/have-job-based-coverage/).**

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace, please visit: **healthcare.gov** or call **800-318-2596.**

Important Notice from Clarkson Construction About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Clarkson Construction and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Clarkson Construction has determined that the prescription drug coverage offered by the Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Your current Clarkson Construction coverage pays for other health expenses in addition to prescription drug. If you decide to join a Medicare drug plan, your current Clarkson Construction will not be affected. If you elect Medicare drug coverage in addition to your Clarkson Construction coverage, the pharmacy benefits you are eligible for under your Clarkson Construction coverage will coordinate with your Medicare drug plan. The prescription drug coverage(s) offered by the BCBS of Kansas City Medical Plans is/are:

Benefit Summary	Spira Care EPO	HSA Plan	Traditional PPO	
Annual Drug Deductible	N/A	N/A	N/A	
Tier I	$15	Deductible	$15	
Tier II	$50	Deductible	$70	
Tier III	Deductible	Deductible	$110	
Tier IV	Deductible	Deductible	$200	
Tier V	Deductible	Deductible	$200	

If you do decide to join a Medicare drug plan and drop your current Clarkson Construction coverage, be aware that you and your dependents will not be able to get this coverage back except in limited cases (such as a special enrollment event, or open enrollment, as explained in our plan's summary plan description).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Clarkson Construction and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Clarkson Construction** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Date:

Name of Entity/Sender: **Clarkson Construction**

Contact—Position/Office: **Tara McKinney**

Address: **1737 McGee Street**
Kansas City, MO 64106

Phone Number: **816-483-8800**

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balancing Billing.)
Appeal: A request for your health insurer or plan to review a decision or a grievance again.
Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.
Co-Insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount (Jane pays 20%, her plan pays 80%.)
Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.
Co-Payment: a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan plays 0%.)
Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.
Emergency Room Care: Emergency services received in an emergency room.
Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.
Grievance: A complaint that you communicate to your health insurer or plan.
Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/ or outpatient settings.
Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Home Health Care: Health care services a person receives at home.
Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires as overnight stay. An overnight stay for observation could be outpatient care.
Hospital Outpatient Care: care in a hospital that usually doesn't require an overnight stay.
In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out- of-network co-insurance.
In-Network Co-Payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payment usually are less than out-of-network co-payments.
Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.
Network: The facilitates, providers and suppliers your health insurer or plan has contracted with to provide health care services.
Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.
Out-of-Network Co-Insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.
Out-of-Network Co-Payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of- network co-payments usually are more than in-network copayments.
Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begin to pay 100% of the allowed amount. This limit never included your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit (Jane pays 0%, her plan pays 100%.)
Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O.- Doctor of Osteopathic Medicine) provides or coordinates.
Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.
Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.
Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.
Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.
Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.
Prescription Drugs: Drugs and medications that by law require a prescription.
Primary Care Physician: A physician (M.D. – Medical Doctor or D.O.- Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Primary Care Provider: A physician (M.D.- Medical Doctor or D.O.-Doctor of Osteopathic Medicine), Nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.
Provider: A physician (M.D. – Medical Doctor or D.O.- Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.
Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part the body because of birth defects, accidents, injuries or medical conditions.
Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or nursing home.
Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to a diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.
UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.